Patient Management Module

HIV TEST

CLIENT NAME: (Last, First,, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Was HIV Test Offered? (Check one) **G** Yes **G** No **G** Unknown **If Yes, Date Offered** ____/____/____

Was HIV Test Administered? (Check one) **G** Yes **G** No **G** Unknown **If Yes, Date of Test** ____/____/____

HIV Status (Check one)

- **G** Positive
- **G** Negative
- **G** Done, Results Unknown
- **G** Indeterminate
- **G** Unknown

If Not Tested, Reason (Check one)

- **G** Previously Positive **Previous Positive Test Date:** ___/___/___
- **G** Previously Negative **Previous Negative Test Date:** ___/___/___
- **G** Referred Elsewhere
- **G** Client Denied
- **G** Other (specify reason)_____

If Positive, Based on

- **G** Medical Documentation
- **G** Patient History
- **G** Unknown

CDC AIDS Patient # _____
State HIV/AIDS Patient # _____
City HIV/AIDS Patient # _____

Client Post Counseling (Check one)

- **G** Yes **Date of Post Test Counseling** ____/____/____
- **G** No

User Defined Variable Information (If needed)

General Comments (Not to be entered into TIMS)

_____ ____/_____/____
Completed By Date